

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services</b> <i>(One Application Per Location)</i>	Williams
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Williams
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
  - G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.
- III. Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.
- IV. For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:
- A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:
    - 1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:
      - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
      - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
      - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*
    - 2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:
      - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
      - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
      - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*
    - 3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not

available at the time of application. This form may be found on the ODH website or available upon request; *and*,

4. **A new Supplier Information Form.** (If Organization has moved).

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**V. For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed W-9 form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Supplier Information Form

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Authorization Agreement for Direct Deposit of EFT Payments form (optional).

If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**VI. By June 1, 2017, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my

knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

5/23/16  
Date

Janet Burkholder  
Signature of Person Completing Application

Janet Burkholder, Bookkeeper  
[Print Name & Title]

**Application to be submitted to:**

Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor  
Columbus, OH 43215  
Attention: Marius Igwe

Phone: 614.466.4634  
Email: [Marius.Igwe@odh.ohio.gov](mailto:Marius.Igwe@odh.ohio.gov)

# Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2

Name (as shown on your income tax return)  
*CPC Women's Health Resource*  
Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership  
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... ☐ Exempt payee  
☒ Other (see instructions) ▶ *Non-Profit*

Address (number, street, and apt. or suite no.)  
*1410 W. High St.*  
City, state, and ZIP code  
*Dryan OH 43506*  
List account number(s) here (optional)

Requester's name and address (optional)  
*Ohio Department of Health*

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
OR
Employer identification number

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions:** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ *Janet Puschelder*

Date ▶ *5/17/16*

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



## SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

### SECTION 1 - PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-9ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATION

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS - (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM)

☒ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS

☐ CHANGE OF PO DISPATCH METHOD

☐ OTHER

### SECTION 2 - PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

CPC Women's Health Resource

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):

### SECTION 3 - REMIT TO ADDRESS (REQUIRED)

ADDRESS:

1410 W. High St.

COUNTY:

Williams

ADDRESS (CONT.):

CITY:

Bryan

STATE:

OH

ZIP CODE:

43506

CONTACT NAME:

Janet Burkholder

PHONE:

419.636.5692

FAX:

419.636.3096

E-MAIL:

janet@cpowh.org

### SECTION 4 - ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:

COUNTY:

ADDRESS (CONT.):

CITY:

STATE:

ZIP CODE:

**SECTION 5 - CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW - (BUSINESSES ONLY)**

NAME: Janet Burkholder

E-MAIL: janet@openwo.org

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ ADDITIONAL STRATEGIC SOURCING CONTACT

☐ REPLACE SS CONTACT (WILL BE MARKED INACTIVE)

NAME:

E-MAIL:

**SECTION 6 - PAYMENT TERMS (PLEASE CHECK ONE - IF NONE IS SELECTED THEN NET 30 WILL APPLY)**

Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ 2/10 NET 30

☐ NET 30

**SECTION 7 - PURCHASE ORDER DISTRIBUTION - OTHER THAN USRS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)**

E-MAIL OR FAX:

**SECTION 8 - PLEASE SIGN & DATE (REQUIRED)**

PRINT NAME:

Janet Burkholder

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

Janet Burkholder

DATE:

6-6-16

**SECTION 9 - STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/E-MAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

**SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:**

Email: supplier@ohio.gov

Fax: 1 (614) 485-1052

Mail: Ohio Shared Services  
Attn: Supplier Operations  
P.O. Box 182880, Columbus, OH 43218-2880

**QUESTIONS? PLEASE CONTACT:**

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

Website: www.ohiosharedservices.ohio.gov/

Email: supplier@ohio.gov



## CHANGE OF SUPPLIER NAME FORM

This form must be submitted with a completed Supplier Information Form and a completed W9 Form

### SECTION 1 – NEW NAME INFORMATION

NEW LEGAL BUSINESS NAME:

CPC Women's Health Resource

NEW DBA NAME/S (IF APPLICABLE):

### SECTION 2 – PREVIOUS NAME INFORMATION

PREVIOUS LEGAL BUSINESS NAME:

Community Pregnancy Centers of Northwest Ohio

PREVIOUS DBA NAME/S (IF APPLICABLE):

### SECTION 3 – REASON FOR THE NAME CHANGE AND ADDITIONAL COMMENTS

The board felt the new name better reflected the services we offer.

### SECTION 4 – TAX IDENTIFICATION NUMBER

FEDERAL TAX ID (TIN), EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (REQUIRED<sup>1</sup>):

### SECTION 5 – PLEASE SIGN AND DATE

PRINT NAME:

Janet Barkholder

DATE:

6-6-16

AUTHORIZED  
SIGNATURE:

Janet Barkholder

CONTACT PHONE NUMBER:

419-636-5692

CONTACT

E-MAIL ADDRESS

janet@cpnw.ohio.gov

Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.  
<sup>1</sup> Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each vendor.

### SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

E-mail:

supplier@ohio.gov

Fax:

1 (614) 485-1052

Mail:

Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880 Cols., OH 43218-2880

### QUESTIONS? PLEASE CONTACT:

Phone:

1 (877) OHIO-SS1 (1-877-844-6771)

1 (614) 338-4781

Website:

[www.OhioSharedServices.ohio.gov](http://www.OhioSharedServices.ohio.gov)

E-mail:

[supplier@ohio.gov](mailto:supplier@ohio.gov)





CASH ONLY JEAL Check-Cock SECURITY FEATURES LISTED ON BACK INDICATE NO TAMPERING OR COPYING

CPC Women's Health Resource  
1410 W HIGH STREET  
BRYAN, OH 43506

FIRST FED BANK OF THE MIDWEST  
ADRIAN, MI 49221  
56-7085/2412

22255

1/11/2016

PAY TO THE  
ORDER OF

Janet Burkholder

Ninety-Five and 91/100

DOLLARS

PROTECTED AGAINST FRAUD

Janet Burkholder  
19063 US20A  
Wauseon, OH 43567

MEMO

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1499 N. Glenwood Ave.
<b>City, State Zip code</b>	Wauseon, OH 43567
<b>County of Location Providing Services (One Application Per Location)</b>	Fulton
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Fulton, Lucas
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
- G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.
- III. Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.
- IV. For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:
- A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:
1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*
  2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*
  3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not

available at the time of application. This form may be found on the ODH website or available upon request; and,

4. **A new Supplier Information Form.** (If Organization has moved).

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**V. For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed W-9 form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Supplier Information Form

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Authorization Agreement for Direct Deposit of EFT Payments form (optional).

If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**VI. By June 1, 2017, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my

knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

5/23/16  
Date

Janet Burkholder  
Signature of Person Completing Application

Janet Burkholder, Bookkeeper  
[Print Name & Title]

**Application to be submitted to:**

Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor  
Columbus, OH 43215  
Attention: Marius Igwe

Phone: 614.466.4634  
Email: [Marius.Igwe@odh.ohio.gov](mailto:Marius.Igwe@odh.ohio.gov)

# Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)

*CPC Women's Health Resource*

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership

☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....

☒ Other (see instructions) ▶ *Non-Profit*

☐ Exempt  
payee

Address (number, street, and apt. or suite no.)

*1410 W. High St.*

City, state, and ZIP code

*Dryan OH 43506*

List account number(s) here (optional)

Requester's name and address (optional)

*Ohio Department of Health*

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

OR

Employer identification number

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions:** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign  
Here

Signature of  
U.S. person ▶

*Janet Purchlander*

Date ▶ *3/17/16*

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



## SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

### SECTION 1 - PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-9ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATION

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS - (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM) ☒ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS ☐ CHANGE OF PO DISPATCH METHOD ☐ OTHER \_\_\_\_\_

### SECTION 2 - PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

CPC Women's Health Resource

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN)<sup>1</sup>:

### SECTION 3 - REMIT TO ADDRESS (REQUIRED)

ADDRESS:

1410 W. High St.

COUNTY:

Williams

ADDRESS (CONT.):

CITY:

Bryan

STATE:

OH

ZIP CODE:

43506

CONTACT NAME:

Janet Burkholder

PHONE:

419-636-5692

FAX:

419-436-3096

E-MAIL:

janet@cpcnwc.org

### SECTION 4 - ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:

COUNTY:

ADDRESS (CONT.):

CITY:

STATE:

ZIP CODE:



**SECTION 5 - CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW - (BUSINESSES ONLY)**

NAME: Janet Burkholder

E-MAIL: janet@openwa.org

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ ADDITIONAL STRATEGIC SOURCING CONTACT ☐ REPLACE SS CONTACT (WILL BE MARKED INACTIVE)

NAME:

E-MAIL:

**SECTION 6 - PAYMENT TERMS (PLEASE CHECK ONE - IF NONE IS SELECTED THEN NET 30 WILL APPLY)**

Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ 2/10 NET 30 ☐ NET 30

**SECTION 7 - PURCHASE ORDER DISTRIBUTION-OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING P.Os)**

E-MAIL OR FAX:

**SECTION 8 - PLEASE SIGN & DATE (REQUIRED)**

PRINT NAME:

Janet Burkholder

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

Janet Burkholder

DATE:

6-6-16

**SECTION 9 - STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/E-MAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.  
Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

**SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:**

Email: supplier@ohio.gov

Fax: 1 (614) 485-1052

Mail: Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880, Columbus, OH 43218-2880

**QUESTIONS? PLEASE CONTACT:**

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

Website: www.ohiosharedservices.ohio.gov/

Email: supplier@ohio.gov



## CHANGE OF SUPPLIER NAME FORM

This form must be submitted with a completed Supplier Information Form and a completed W9 Form

### SECTION 1 – NEW NAME INFORMATION

NEW LEGAL BUSINESS NAME:

CPC Women's Health Resource

NEW DBA NAME/S (IF APPLICABLE):

### SECTION 2 – PREVIOUS NAME INFORMATION

PREVIOUS LEGAL BUSINESS NAME:

Community Pregnancy Centers of Northwest Ohio

PREVIOUS DBA NAME/S (IF APPLICABLE):

### SECTION 3 – REASON FOR THE NAME CHANGE AND ADDITIONAL COMMENTS

The board felt the new name better reflected the services we offer.

### SECTION 4 – TAX IDENTIFICATION NUMBER

FEDERAL TAX ID (TIN), EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (REQUIRED\*):

### SECTION 5 – PLEASE SIGN AND DATE

PRINT NAME: Janet Burkholder

AUTHORIZED SIGNATURE: Janet Burkholder

CONTACT E-MAIL ADDRESS: janet@cpnwo.org

DATE:

6-6-16

CONTACT PHONE NUMBER:

419-636-5692

Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.  
\* Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each vendor.

### SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

E-mail: [supplier@ohio.gov](mailto:supplier@ohio.gov)  
Fax: 1 (614) 485-1052  
Mail: Ohio Shared Services  
Attn: Supplier Operations  
P.O. Box 182880 Cols., OH 43218-2880

### QUESTIONS? PLEASE CONTACT:

Phone: 1 (877) OHIO-SS1 (1-877-644-8771)  
1 (614) 338-4781  
Website: [www.OhioSharedServices.ohio.gov](http://www.OhioSharedServices.ohio.gov)  
E-mail: [supplier@ohio.gov](mailto:supplier@ohio.gov)



Please review the instructions available on page 2 prior to completing this form.

## AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

### SECTION 1: CONTACT INFORMATION

TAX IDENTIFICATION NUMBER (TIN)  
OR SOCIAL SECURITY NUMBER (SSN)

Please note: We are required to obtain your Tax Identification Number pursuant to Section 6109 of the Internal Revenue Code so that we can report income paid to you to the IRS as required by law.

NAME OF COMPANY OR INDIVIDUAL

CPC Women's Health Resource

ADDRESS

1410 W. High St.

STREET

SUITE / ROOM #

Bryan

CITY

OH

STATE

43504

ZIP CODE

PHONE

419-636-5692

EMAIL ADDRESS

janet@cpcnw.org

CHOOSE THE STATE AGENCY FROM  
WHICH YOU ARE BEING REIMBURSED

☐ DODD

☐ OOD/PCA

☐ LOTTERY WINNER

☒ ALL OTHER

☐ MEDICAID PROVIDER  
(PROVIDER, NPI, ASSIGNING  
AUTHORITY required)

PROVIDER#

NPI#

ASSIGNING  
AUTHORITY

TYPE OF TRANSACTION

☒ ADD

☐ CHANGE/UPDATE

☐ INACTIVATE

### SECTION 2: NEW FINANCIAL INFORMATION

BANK VERIFICATION MUST BE ATTACHED

NEW FINANCIAL  
INSTITUTION NAME  
ACCOUNT TYPE

First Fed Bank of the mid

☒ CHECKING ☐ SAVINGS

NEW ACCOUNT NUMBER

Account Number supplied must match attached bank verification

NEW TRANSIT ROUTING

/ABA NUMBER

Routing Number supplied must match attached bank verification

### SECTION 3: PRIOR FINANCIAL INFORMATION

MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT

PRIOR FINANCIAL INSTITUTION  
NAME

PRIOR ACCOUNT NUMBER

Account Number supplied must match previous Account Number on file

PRIOR TRANSIT ROUTING

/ABA NUMBER

Routing Number supplied must match previous Routing Number on file

### SECTION 4: READ THE AGREEMENT, SIGN, & DATE DIGITAL/TYPED AND STAMPED SIGNATURES ARE NOT ACCEPTED AT THIS TIME

☒ I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.

☐ Medicaid PROVIDERS - I have ensured the Name, Address, TIN, NPI# & Provider Number matches the information in the MITS Medicaid Web Portal.

☒ I have printed and signed the form.

X

Janet Parkholder

Janet Parkholder

3/23/16

Select one of the following methods to submit this form:

E mail:

supplier@ohio.gov

Mail:

Ohio Shared Services, Attn: Supplier Operations  
P O Box 182880 Columbus, OH 43218-2880

Fax:

1-614-485-1052

CASH ONLY LEAVE CHECK LOCK™ SECURITY FEATURES LISTED ON BACK INDICATE NO TAMPERING OR COPYING

CPC Women's Health Resource  
1410 W HIGH STREET  
BRYAN, OH 43506

FIRST FED BANK OF THE MIDWEST  
ADRIAN, MI 48221  
56-7085/2412

22255

1/14/2016

PAY TO THE  
ORDER OF

Janet Burkholder

Ninety-Five and 95/100

DOLLARS

PROTECTED AGAINST FRAUD

Janet Burkholder  
19063 DS20A  
Wauseon, OH 43567

MEMO





# OHIO DEPARTMENT OF HEALTH

246 North High Street  
Columbus, Ohio 43215

614/466-3543  
[www.odh.ohio.gov](http://www.odh.ohio.gov)

John R. Kasich/Governor

Richard Hodges/Director of Health

Janet Burkholder  
CPC Women's Health Resource  
1410 W. High Street  
Bryan, OH 43506.

Tax ID: [REDACTED]

Dear Burkholder:

Thank you for your interest in the Choose Life Program and for your application for the Choose Life Funding. Your application has been approved for the following county(s) in the amount(s) of:

- Henry \$60
- Fulton \$140
- Defiance \$240
- Paulding \$160
- Putnam \$100
- Van Wert \$60
- Wood \$170
- Williams \$60

Your application was not approved for the following county(s) for the following reason(s):

- Lucas other applicant organization located in county.

Enclosed is a copy of your contract as submitted. You should receive your award totaling \$930 within the next 30 days.

If you have any questions about the Choose Life Program, please contact Marius Igwe at 614-466-4634. Again, thank you for your interest.

Sincerely,

Richard Hodges  
Director of Health, MPA

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services (One Application Per Location)</b>	Williams
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service This location serves women from the following counties:</b>	Williams
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
- G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.
- III. Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.
- IV. For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:
- A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:
1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*
  2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*
  3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not

available at the time of application. This form may be found on the ODH website or available upon request; and,

4. **A new Supplier Information Form.** (if Organization has moved).

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**V. For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed W-9 form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Supplier Information Form

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Authorization Agreement for Direct Deposit of EFT Payments form (optional).

If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**VI. By June 1, 2017, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my



knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

5/23/16  
Date

Janet Burkholder  
Signature of Person Completing Application

Janet Burkholder, Bookkeeper  
[Print Name & Title]

**Application to be submitted to:**

Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor  
Columbus, OH 43215  
Attention: Marius Igwe

Phone: 614.466.4634

Email: [Marius.Igwe@odh.ohio.gov](mailto:Marius.Igwe@odh.ohio.gov)

# Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)

*CPC Women's Health Resource*

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership  
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... ☐ Exempt payee  
☒ Other (see instructions) ▶ *Non-Profit*

Address (number, street, and apt. or suite no.)

*1410 W. High St.*

City, state, and ZIP code

*Dryan OH 43506*

List account number(s) here (optional)

Requester's name and address (optional)

*Ohio Department of Health*

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions:** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the Instructions on page 4.

Sign  
Here

Signature of  
U.S. person ▶

*Janet Purcell*

Date ▶ *5/17/16*

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



## SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

### SECTION 1 - PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-9ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATION

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS - (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM)

☒ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS

☐ CHANGE OF PO DISPATCH METHOD

☐ OTHER

### SECTION 2 - PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

CPC Women's Health Resource

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):

### SECTION 3 - REMIT TO ADDRESS (REQUIRED)

ADDRESS:

1410 W. High St.

COUNTY:

Williams

ADDRESS (CONT.):

CITY:

Bryan

STATE:

OH

ZIP CODE:

43506

CONTACT NAME:

Janet Burkholder

PHONE:

419-636-5692

FAX:

419-436-3096

E-MAIL:

janet@cpcnwc.org

### SECTION 4 - ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:

COUNTY:

ADDRESS (CONT.):

CITY:

STATE:

ZIP CODE:

**SECTION 5 - CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW - (BUSINESSES ONLY)**

NAME: Janet Burkholder

E-MAIL: janet@openwo.org

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ ADDITIONAL STRATEGIC SOURCING CONTACT

☐ REPLACE SS CONTACT (WILL BE MARKED INACTIVE)

NAME:

E-MAIL:

**SECTION 6 - PAYMENT TERMS (PLEASE CHECK ONE - IF NONE IS SELECTED THEN NET 30 WILL APPLY)**  
Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ 2/10 NET 30

☐ NET 30

**SECTION 7 - PURCHASE ORDER DISTRIBUTION - OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)**

E-MAIL OR FAX:

**SECTION 8 - PLEASE SIGN & DATE (REQUIRED)**

PRINT NAME:

Janet Burkholder

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

Janet Burkholder

DATE:

6-6-16

**SECTION 9 - STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/E-MAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.  
Pursuant to 28 USC 6109, the state is required to collect TINEIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

**SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:**

Email: supplier@ohio.gov

Fax: (614) 485-1052

Mail: Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880 Cols. OH 43218-2880

**QUESTIONS? PLEASE CONTACT:**

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

Website: www.ohiosharedservices.ohio.gov/

Email: supplier@ohio.gov



## CHANGE OF SUPPLIER NAME FORM

This form must be submitted with a completed Supplier Information Form and a completed W9 Form

### SECTION 1 - NEW NAME INFORMATION

NEW LEGAL BUSINESS NAME:

CPC Women's Health Resource

NEW DBA NAME/S (IF APPLICABLE):

### SECTION 2 - PREVIOUS NAME INFORMATION

PREVIOUS LEGAL BUSINESS NAME:

Community Pregnancy Centers of Northwest Ohio

PREVIOUS DBA NAME/S (IF APPLICABLE):

### SECTION 3 - REASON FOR THE NAME CHANGE AND ADDITIONAL COMMENTS

The board felt the new name better reflected the services we offer.

### SECTION 4 - TAX IDENTIFICATION NUMBER

FEDERAL TAX ID (TIN), EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (REQUIRED):

### SECTION 5 - PLEASE SIGN AND DATE

PRINT NAME:

Janet Barkholder

AUTHORIZED SIGNATURE:

Janet Barkholder

DATE:

6-6-16

CONTACT

E-MAIL ADDRESS:

janet@cpnwwo.org

CONTACT PHONE NUMBER:

419-636-5692

Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each vendor.

### SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

E-mail:

[supplier@ohio.gov](mailto:supplier@ohio.gov)

Fax:

1 (614) 485-1052

Mail:

Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880 Cols., OH 43218-2880

### QUESTIONS? PLEASE CONTACT:

Phone:

1 (877) OHIO-SS1 (1-877-644-8771)

1 (614) 338-4781

Website:

[www.OhioSharedServices.ohio.gov](http://www.OhioSharedServices.ohio.gov)

E-mail:

[supplier@ohio.gov](mailto:supplier@ohio.gov)



Please review the instructions available on page 2 prior to completing this form.

## AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

### SECTION 1: CONTACT INFORMATION

TAX IDENTIFICATION NUMBER (TIN)  
OR SOCIAL SECURITY NUMBER (SSN)

[REDACTED]

Please note: We are required to obtain your Tax Identification Number pursuant to Section 6109 of the Internal Revenue Code so that we can report income paid to you to the IRS as required by law.

NAME OF COMPANY OR INDIVIDUAL

CPC Women's Health Resource

ADDRESS

NAME

1410 W. High St.

STREET

SUITE / ROOM #

Bryan

CITY

OH

STATE

43506

ZIP CODE

PHONE

419-636-5692

EMAIL ADDRESS

janet@cpcnwo.org

CHOOSE THE STATE AGENCY FROM  
WHICH YOU ARE BEING REIMBURSED

☐ DODD

☐ OOD/PCA

☐ LOTTERY WINNER

☒ ALL OTHER

☐ MEDICAID PROVIDER  
(PROVIDER#, NPI#, ASSIGNING  
AUTHORITY required)

PROVIDER#

NPI#

ASSIGNING  
AUTHORITY

TYPE OF TRANSACTION

☒ ADD

☐ CHANGE/UPDATE

☐ INACTIVATE

### SECTION 2: NEW FINANCIAL INFORMATION

BANK VERIFICATION MUST BE ATTACHED

NEW FINANCIAL  
INSTITUTION NAME

First Fed Bank of the Midwest

ACCOUNT TYPE

☒ CHECKING

☐ SAVINGS

NEW ACCOUNT NUMBER

[REDACTED]

Account Number supplied must match attached bank verification

NEW TRANSIT ROUTING

/ABA NUMBER

Routing Number supplied must match attached bank verification

### SECTION 3: PRIOR FINANCIAL INFORMATION

MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT

PRIOR FINANCIAL INSTITUTION  
NAME

[REDACTED]

PRIOR ACCOUNT NUMBER

[REDACTED]

Account Number supplied must match previous Account Number on file

PRIOR TRANSIT ROUTING

/ABA NUMBER

[REDACTED]

Routing Number supplied must match previous Routing Number on file

### SECTION 4: READ THE AGREEMENT, SIGN, & DATE

DIGITAL/TYPED AND STAMPED SIGNATURES ARE NOT ACCEPTED AT THIS TIME

I have read the agreement and agree to the terms and conditions of the agreement. I understand that the information provided on this form is for the purpose of obtaining reimbursement for services provided to me. I understand that the information provided on this form is for the purpose of obtaining reimbursement for services provided to me. I understand that the information provided on this form is for the purpose of obtaining reimbursement for services provided to me.

☒ I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.

☐ Medicaid PROVIDERS - I have ensured the Name, Address, TIN, NPI# & Provider Number matches the information in the MITS Medicaid Web Portal.

☒ I have printed and signed the form.

X

Janet Burkholder

Janet Burkholder

5/23/16

E mail:

supplier@ohio.gov

Select one of the following methods to submit this form:

Mail:

Ohio Shared Services, Attn: Supplier Operations  
P.O. Box 182880 Columbus, OH 43218-2880

Fax:

1-614-485-1052

CASH ONLY. EALY CANCELLATION. SECURITY FEATURES LISTED ON BACK INDICATE NO TAMPERING OR COPYING.

CPC Women's Health Resource  
1410 W HIGH STREET  
BRYAN, OH 43506

FIRST FED BANK OF THE MIDWEST  
ADRIAN, MI 49221  
56-7085/2412

22255

1/13/2016

PAY TO THE  
ORDER OF

Janet Burkholder

Ninety-Five and 91/100

PROTECTED AGAINST FRAUD

DOLLARS

Janet Burkholder  
19063 US20A  
Wauseon, OH 43567

MEMO





**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	
<b>Street Address</b>	1330 N. Scott St.
<b>City, State Zip code</b>	Napoleon, OH 43545
<b>County of Location Providing Services (One Application Per Location)</b>	Henry
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Henry
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;



- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
- G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.
- III. Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.
- IV. For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:
- A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:
1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*
  2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:
    - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
    - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
    - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*
  3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not

available at the time of application. This form may be found on the ODH website or available upon request; and,

4. **A new Supplier Information Form.** (If Organization has moved).

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**V. For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed W-9 form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Supplier Information Form

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Authorization Agreement for Direct Deposit of EFT Payments form (optional).

If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**VI. By June 1, 2017, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my

knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

5/23/16  
Date

Janet Burkholder  
Signature of Person Completing Application

Janet Burkholder, Bookkeeper  
[Print Name & Title]

**Application to be submitted to:**

Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor  
Columbus, OH 43215  
Attention: Marius Igwe

Phone: 614.466.4634  
Email: Marius.Igwe@odh.ohio.gov

**Request for Taxpayer  
Identification Number and Certification**

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)

*CPC Women's Health Resource*

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership

☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....

☒ Other (see instructions) ▶ *Non-Profit*

☐ Exempt  
payee

Address (number, street, and apt. or suite no.)

*1410 W. High St.*

City, state, and ZIP code

*Cryan OH 43506*

Requester's name and address (optional)

*Ohio Department of Health*

List account number(s) here (optional)

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

**Part II Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign  
Here

Signature of  
U.S. person ▶

*Janet Pundlicher*

Date ▶ *5/17/16*

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



## SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

### SECTION 1 - PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-9ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATION

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS - (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM)

☒ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS

☐ CHANGE OF PO DISPATCH METHOD

☐ OTHER \_\_\_\_\_

### SECTION 2 - PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

CPC Women's Health Resource

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):



### SECTION 3 - REMIT TO ADDRESS (REQUIRED)

ADDRESS:

1410 W. High St.

COUNTY:

Williams

ADDRESS (CONT.):

CITY:

Bryan

STATE:

OH

ZIP CODE:

43506

CONTACT NAME:

Janet Burkholder

PHONE:

419-636-5692

FAX:

419-636-3096

E-MAIL:

janet@cpcnwco.org

### SECTION 4 - ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:

COUNTY:

ADDRESS (CONT.):

CITY:

STATE:

ZIP CODE:

**SECTION 5 - CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW - (BUSINESSES ONLY)**

NAME: Janet Burkholder

E-MAIL: janet@cpnwo.org

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ ADDITIONAL STRATEGIC SOURCING CONTACT ☐ REPLACE SS CONTACT (WILL BE MARKED INACTIVE)

NAME:

E-MAIL:

**SECTION 6 - PAYMENT TERMS (PLEASE CHECK ONE - IF NONE IS SELECTED THEN NET 30 WILL APPLY)**  
Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ 2/10 NET 30 ☐ NET 30

**SECTION 7 - PURCHASE ORDER DISTRIBUTION - OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)**

E-MAIL OR FAX:

**SECTION 8 - PLEASE SIGN & DATE (REQUIRED)**

PRINT NAME:

Janet Burkholder

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

Janet Burkholder

DATE:

6-6-16

**SECTION 9 - STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/E-MAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

**SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:**

Email: supplier@ohio.gov

Fax: 1 (814) 485-1052

Mail: Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880, Columbus, OH 43218-2880

**QUESTIONS? PLEASE CONTACT:**

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

Website: www.ohiosharedservices.ohio.gov/

Email: supplier@ohio.gov



## CHANGE OF SUPPLIER NAME FORM

This form must be submitted with a completed Supplier Information Form and a completed W9 Form

### SECTION 1 - NEW NAME INFORMATION

NEW LEGAL BUSINESS NAME:

CPC Women's Health Resource

NEW DBA NAME/S (IF APPLICABLE):

### SECTION 2 - PREVIOUS NAME INFORMATION

PREVIOUS LEGAL BUSINESS NAME:

Community Pregnancy Centers of Northwest Ohio

PREVIOUS DBA NAME/S (IF APPLICABLE):

### SECTION 3 - REASON FOR THE NAME CHANGE AND ADDITIONAL COMMENTS

The board felt the new name better reflected the services we offer.

### SECTION 4 - TAX IDENTIFICATION NUMBER

FEDERAL TAX ID (TIN) EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (REQUIRED):

### SECTION 5 - PLEASE SIGN AND DATE

PRINT NAME: Janet Bartholder

AUTHORIZED SIGNATURE: Janet Bartholder

CONTACT E-MAIL ADDRESS: janet@cpnwo.org

DATE:

6-6-16

CONTACT PHONE NUMBER:

419-636-5692

Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each vendor.

### SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

E-mail: [supplier@ohio.gov](mailto:supplier@ohio.gov)  
Fax: 1 (614) 485-1052  
Mail: Ohio Shared Services  
Attn: Supplier Operations  
P.O. Box 182880 Cols., OH 43218-2880

### QUESTIONS? PLEASE CONTACT:

Phone: 1 (877) OHIO-SS1 (1-877-844-8771)  
1 (614) 338-4781  
Website: [www.OhioSharedServices.ohio.gov](http://www.OhioSharedServices.ohio.gov)  
E-mail: [supplier@ohio.gov](mailto:supplier@ohio.gov)



Please review the instructions available on page 2 prior to completing this form.

## AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

### SECTION 1: CONTACT INFORMATION

TAX IDENTIFICATION NUMBER (TIN)  
OR SOCIAL SECURITY NUMBER (SSN)

Please note: We are required to obtain your Tax Identification Number pursuant to Section 6109 of the Internal Revenue Code so that we can report income paid to you to the IRS as required by law.

NAME OF COMPANY OR INDIVIDUAL

CPC Women's Health Resource

TYPE OF TRANSACTION

ADDRESS

NAME

1410 W. High St.

STREET

SUITE / ROOM #

Bryan

CITY

OH

STATE

43506

ZIP CODE

☒ ADD

☐ CHANGE/UPDATE

☐ INACTIVATE

PHONE

419-636-5692

EMAIL ADDRESS

janet@cpcnw.org

CHOOSE THE STATE AGENCY FROM  
WHICH YOU ARE BEING REIMBURSED

☐ DODD

☐ OOD/PCA

☐ LOTTERY WINNER

☒ ALL OTHER

☐ MEDICAID PROVIDER  
(PROVIDER#, NPI#, ASSIGNING  
AUTHORITY required)

PROVIDER#

NPI#

ASSIGNING  
AUTHORITY

### SECTION 2: NEW FINANCIAL INFORMATION

BANK VERIFICATION MUST BE ATTACHED

NEW FINANCIAL  
INSTITUTION NAME  
ACCOUNT TYPE

First Fed Bank of the midwest

☒ CHECKING ☐ SAVINGS

NEW ACCOUNT NUMBER

Account Number supplied must match attached bank verification

NEW TRANSIT ROUTING  
/ABA NUMBER

Routing Number supplied must match attached bank verification

### SECTION 3: PRIOR FINANCIAL INFORMATION

MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT

PRIOR FINANCIAL INSTITUTION  
NAME

PRIOR ACCOUNT NUMBER

Account Number supplied must match previous Account Number on file

PRIOR TRANSIT ROUTING  
/ABA NUMBER

Routing Number supplied must match previous Routing Number on file

### SECTION 4: READ THE AGREEMENT, SIGN, & DATE (DIGITAL/TYPED AND STAMPED SIGNATURES ARE NOT ACCEPTED AT THIS TIME)

☒ I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.

☐ Medicaid PROVIDERS -- I have ensured the Name, Address, TIN, NPI# & Provider Number matches the Information in the MITS Medicaid Web Portal.

☒ I have printed and signed the form.

X

Janet Parkholder

Janet Parkholder

5/23/16

Select one of the following methods to submit this form:

supplier@ohio.gov

Ohio Shared Services, Attn: Supplier Operations  
P O Box 182880 Columbus, OH 43218-2880

1-614-485-1052



CASH ONLY. ALL OTHER SECURITY FEATURES LISTED ON BACK INDICATE NO TAMPERING OR COPYING.

CPC Women's Health Resource  
1410 W HIGH STREET  
BRYAN, OH 43506

FIRST FED BANK OF THE MIDWEST  
ADRIAN, MI 49221  
56-7085/2412

22255

1/14/2016

PAY TO THE  
ORDER OF

Janet Burkholder

Ninety-Five and 91/100

DOLLARS

Janet Burkholder  
19063 DS20A  
Wauseon, OH 43567

MEMO



1548

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services (One Application Per Location)</b>	Henry
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Henry
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

✓ 548

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services (One Application Per Location)</b>	Fulton
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Fulton, Lucas
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

✓

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services (One Application Per Location)</b>	Defiance
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Defiance, Paulding, Putnam, Van Wert, Wood
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

✓ SAB

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1410 W. High St.
<b>City, State Zip code</b>	Bryan, OH 43506
<b>County of Location Providing Services (One Application Per Location)</b>	Williams
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Williams
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND  
DISTRIBUTION APPLICATION**

**Interested Organizations:** This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

**I. ODH and Organization Information.**

<b>Organization</b>	CPC Women's Health Resource
<b>Federal Tax ID Number</b>	[REDACTED]
<b>Street Address</b>	1997 N. Clinton St.
<b>City, State Zip code</b>	Defiance, OH 43512
<b>County of Location Providing Services (One Application Per Location)</b>	Defiance
<b>Address where ODH should Direct Payment</b>	1410 W. High St. Bryan, OH 43506
<b>Counties of Service</b> <i>This location serves women from the following counties:</i>	Defiance, Paulding, Putnam, Van Wert, Wood
<b>Name of Person and Title completing application</b>	Janet Burkholder, Bookkeeper
<b>Area Code/Phone Number</b>	419-636-5692
<b>Email</b>	janet@cpcnwo.org

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;

- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
  - G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.
- III. Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.
- IV. For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:
- A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:
    - 1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an Independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:
      - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
      - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
      - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*
    - 2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:
      - a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
      - b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
      - c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*
    - 3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not

available at the time of application. This form may be found on the ODH website or available upon request; and,

4. **A new Supplier Information Form.** (if Organization has moved).

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**V. For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed W-9 form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Supplier Information Form

In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed Authorization Agreement for Direct Deposit of EFT Payments form (optional).

If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

<http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx>

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

**VI. By June 1, 2017, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my



knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

5/23/16  
Date

Janet Burkholder  
Signature of Person Completing Application

Janet Burkholder, Bookkeeper  
[Print Name & Title]

**Application to be submitted to:**

Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor  
Columbus, OH 43215  
Attention: Marius Igwe

Phone: 614.466.4634  
Email: Marius.Igwe@odh.ohio.gov

# Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)

*CPC Women's Health Resource*

Business name, if different from above

Check appropriate box ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership

☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....

☒ Other (see instructions) ▶ *Non-Profit*

☐ Exempt payee

Address (number, street, and apt. or suite no.)

*1410 W. High St.*

City, state, and ZIP code

*Dryan OH 43506*

Requester's name and address (optional)

*Ohio Department of Health*

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Notes.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions:** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign  
Here

Signature of  
U.S. person ▶

*Janet Pankholder*

Date ▶ *3/17/16*

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Notes.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



## SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at [www.ohiosharedservices.ohio.gov](http://www.ohiosharedservices.ohio.gov).

### SECTION 1 - PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-9ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATION

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS - (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM)

☒ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS

☐ CHANGE OF PO DISPATCH METHOD

☐ OTHER

### SECTION 2 - PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

CPC Women's Health Resource

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):

### SECTION 3 - REMIT TO ADDRESS (REQUIRED)

ADDRESS:

1410 W. High St.

COUNTY:

Williams

ADDRESS (CONT.):

CITY:

Bryan

STATE:

OH

ZIP CODE:

43506

CONTACT NAME:

Janet Burkholder

PHONE:

419-636-5692

FAX:

419-436-3096

E-MAIL:

janet@cpcnwle.org

### SECTION 4 - ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS:

COUNTY:

ADDRESS (CONT.):

CITY:

STATE:

ZIP CODE:

**SECTION 5 - CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW - (BUSINESSES ONLY)**

NAME: Janet Burkholder

E-MAIL: janet@openwo.org

TO ADD AN ADDITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ ADDITIONAL STRATEGIC SOURCING CONTACT

☐ REPLACE SS CONTACT (WILL BE MARKED INACTIVE)

NAME:

E-MAIL:

**SECTION 6 - PAYMENT TERMS (PLEASE CHECK ONE - IF NONE IS SELECTED THEN NET 30 WILL APPLY)**  
Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ 2/10 NET 30

☐ NET 30

**SECTION 7 - PURCHASE ORDER DISTRIBUTION - OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)**

E-MAIL OR FAX:

**SECTION 8 - PLEASE SIGN & DATE (REQUIRED)**

PRINT NAME:

Janet Burkholder

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED)

Janet Burkholder

DATE:

6-6-16

**SECTION 9 - STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)**

AGENCY CONTACT NAME/E-MAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

**SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:**

Email: supplier@ohio.gov

Fax: 1 (614) 485-1052

Mail: Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880 Columbus, OH 43218-2880

**QUESTIONS? PLEASE CONTACT:**

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)

1 (614) 338-4781

Website: www.ohiosharedservices.ohio.gov/

Email: supplier@ohio.gov



## CHANGE OF SUPPLIER NAME FORM

This form must be submitted with a completed Supplier Information Form and a completed W9 Form

### SECTION 1 – NEW NAME INFORMATION

NEW LEGAL BUSINESS NAME:

CPC Women's Health Resource

NEW DBA NAME/S (IF APPLICABLE):

### SECTION 2 – PREVIOUS NAME INFORMATION

PREVIOUS LEGAL BUSINESS NAME:

Community Pregnancy Centers of Northwest Ohio

PREVIOUS DBA NAME/S (IF APPLICABLE):

### SECTION 3 – REASON FOR THE NAME CHANGE AND ADDITIONAL COMMENTS

The board felt the new name better reflected the services we offer.

### SECTION 4 – TAX IDENTIFICATION NUMBER

FEDERAL TAX ID (TIN) EMPLOYER IDENTIFICATION NUMBER (REQUIRED):

### SECTION 5 – PLEASE SIGN AND DATE

PRINT NAME:

Janet Burkholder

AUTHORIZED SIGNATURE:

Janet Burkholder

DATE:

6-6-16

CONTACT E-MAIL ADDRESS:

janet@cpcnwo.org

CONTACT PHONE NUMBER:

419-636-5692

Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk. Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each vendor.

### SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

E-mail:

supplier@ohio.gov

Fax:

1 (614) 486-1052

Mail:

Ohio Shared Services

Attn: Supplier Operations

P.O. Box 182880 Cois., OH 43218-2880

### QUESTIONS? PLEASE CONTACT:

Phone:

1 (877) OHIO-SS1 (1-877-644-6771)

1 (614) 338-4781

Website:

www.OhioSharedServices.ohio.gov

E-mail:

supplier@ohio.gov



CASH ONLY PLEASE CHECK ALL SECURITY FEATURES LISTED ON BACK INDICATE NO TAMPERING OR COPYING

CPC Women's Health Resource  
1410 W HIGH STREET  
BRYAN, OH 43506

FIRST FED BANK OF THE MIDWEST  
ADRIAN, MI 49221  
56-7085/2412

22255

1/14/2016

PAY TO THE  
ORDER OF

Janet Burkholder

Ninety-Five and 9/100

DOLLARS

PROTECTED AGAINST FRAUD

Janet Burkholder  
19063 US28A  
Wauseon, OH 43567

MEMO



# INVOICE

Invoice #: 0101  
Invoice Date: 09/13/2016  
Purchase Order #: DOH01-0000045579  
OAKS Vendor #: 0000065135

Bill To: Ohio Department of Health  
Bureau of Maternal, Child and Family Health  
P.O. Box 118  
Columbus, Ohio 43216

Remit To: CPC Womens Health Resource  
1410 W High St  
Bryan, Ohio 43506

Quantity	Description	Unit Cost	Amount
1	Provision of Choose Life services for women who are considering adoption.	1	\$ 990.00

Program Approval: [Signature]

Approval Date: 9/13/16 pk to pf

Grand Total

\$990.00



# Purchase Order

Payment Provision: The purchase order number authorizing the delivery of products or services **MUST** be included on the invoice.

## Dept of Health

Supplier:  
0000085135  
CPC WOMENS HEALTH RESOURCE  
1410 W HIGH ST  
BRYAN OH 43508

Dispatch via Print

Purchase Order	Date	Revision	Page
DOB01-0000045579	08/30/2016		1
Payment Terms	Freight Terms	Ship Via	
Net 30	FOB Destination, Prepaid	N/A	
Phone	Currency		
KENNON A HUGHES	USD		

Ship To: Dept of Health  
P003574  
KENNON A HUGHES  
P.O. Box 118  
(614) 468-3543  
Columbus OH 43218-0118  
United States

Bill To: Dept of Health  
P.O. Box 118  
(614) 468-3543  
Columbus OH 43218-0118  
United States

Line-Sch	Quantity	UOM	Unit Price	Extended Amt	Due Date
1- 1	1	AMT	990	990.00	
Choose Life Program					

Schedule Total 990.00

Item Total 990.00

ODH Contact: Marius Igwe 614-468-4634 Contract# 8022

Total PO Amount 990.00

The Director of Budget and Management certifies that there is a balance available in the appropriation not already obligated to pay existing obligations in an amount at least equal to the portion of the contract, agreement, obligation resolution or order to be performed in the current fiscal year.

Department Head

Richard Hodges, MPA  
Director of Health



By accepting this purchase order, Vendor hereby certifies that it is in full compliance with ORC Section 3517.13 as it relates to campaign finance contributions.



# OHIO DEPARTMENT OF HEALTH

246 North High Street  
Columbus, Ohio 43215

614/466-3543  
[www.odh.ohio.gov](http://www.odh.ohio.gov)

John R. Kasich/Governor

Richard Hodges/Director of Health

Janet Burkholder  
CPC Women's Health Resource  
1410 W. High Street  
Bryan, OH 43506

Tax ID [REDACTED]

Dear Ms. Burkholder:

Thank you for your interest in the Choose Life Program and for your application for the Choose Life funding. Application(s) was approved for the following county(s) in the amount(s) of:

- Henry \$ 60.00
- Fulton \$ 140.00
- Defiance \$ 240.00
- Paulding \$ 160.00
- Putnam \$ 100.00
- Van Wert \$ 60.00
- Wood \$ 170.00
- Williams \$ 60.00

Application(s) was not approved for funding in the following county(s) for the following reason(s):

- Lucas Other applicant organization located in county

Enclosed is a copy of the contract as was submitted. You should receive an award totaling \$990.00 within the next 30 days.

If you have any questions, please contact the Choose Life Program consultant Marius Igwe at [Marius.Igwe@odh.ohio.gov](mailto:Marius.Igwe@odh.ohio.gov) or phone 614-466-4634.

Sincerely,

  
Richard Hodges, MPA  
Director of Health